

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MEDICAID BULLETIN

TO: Medicaid Adolescent Pregnancy Prevention Services (MAPPS) Providers

SUBJECT: Changes in Medicaid Policy

Effective July 1, 2005, the South Carolina Department of Health and Human Services (DHHS) will implement the following revised standards for MAPPS policies.

- **Credentials for Individuals Providing MAPPS**

Individuals providing MAPPS assessments and annual intervention/case plan updates must be licensed or certified by appropriate state authorities as a health care professional. DHHS recognizes the following as eligible:

Licensed Professional Counselor (LPC), Licensed Marriage and Family Counselor (LMFC), Licensed Psycho-Educational Specialist (LPES), Certified Health Educator, Licensed Practical Nurse (LPN), Registered Nurse (RN), Nurse Practitioner (NP), Certified Nurse Specialist (CNS), Certified Nurse Midwife (CNM), Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Licensed Independent Social Worker-Clinical Practice (LISW-CP), Licensed Independent Social Worker-Advanced Practice (LISW-AP), Licensed Psychologist, and Licensed Physician Assistant.

Unlicensed or non-certified staff must be **directly** supervised by a licensed or certified health care professional in order to provide individual and/or group educational counseling.

For Medicaid billing purposes, direct supervision means that the supervising licensed or certified health care professional is accessible when the services are being provided; and, the supervising licensed or certified health care professional is responsible for all services rendered, fees charged and reimbursement received. The supervising licensed or certified health care professional must co-sign all documentation provided by unlicensed/non-certified staff, indicating that he or she accepts responsibility for the service rendered.

- **Family Planning Training**

Staff providing direct services must attend a minimum of twenty (20) hours of family planning training per contract year. New staff providing direct services must receive at least twelve (12) of the 20 hours of family planning training during the first quarter of employment as a MAPPS provider. Unlicensed/non-certified staff providing individual educational/counseling sessions must also attend an approved individualized counseling training prior to providing individual sessions. Documentation of training hours should be kept in personnel files and available to DHHS staff for audit purposes.

- **Eligibility Criteria**

The participant must be a Medicaid beneficiary. The age limit for Medicaid participants in the MAPPS program is 10 through 18 years of age. Services to beneficiaries after the date of his/her nineteenth (19) birthday will not be billable to Medicaid.

- **Risk Factors**

Participants must have one or more of the following risk factors:

- Parent(s) were teen parents
- Sibling is pregnant and/or a teen parent
- Participant is a teen parent
- Peer pressure to engage in sexual activity is identified as a problem by the adolescent
- Participant is sexually active and/or has a history of sexual abuse

- **Assessment and Case Plan**

A basic screening assessment must be face-to-face, completed and filed in each participant's record. It must include all information contained in the Screening Form in Attachment 1 along with a description of services to be provided. This screening should be billed as T1023-FP. Relevant information should be documented on social, psychological, environmental, and health risk factors that justify the delivery of MAPPS to the participant. A written intervention case plan must be completed based on the results of the assessment and placed in the participant's record. The assessment and the case plan must be completed prior to providing individual or group educational/counseling sessions. The plan must include family planning goals and objectives based on the assessment; expected time frames for completion of the goals and objectives; the worker's signature, the signature of the participant; the signature of the parent/caregiver; and the date of agreement. **The assessment and the case plan must be completed by a licensed or certified health care professional only and must be updated at least annually or whenever additional risk factors are identified.**

- **Individual Sessions**

An individual session is a face-to-face counseling session. Individual sessions may be with the participant or the participant and parent. Individual sessions billed as procedure code S9445-FP, will be measured in 15-minute increments and address a minimum of three (3) documentation points plus the client's response (Attachment 1–Documentation Points). This procedure code may also be used for billing of the six (6) month review of the assessment/case plan. Providers must take reasonable steps to ensure that their communication with the participant is confidential. **Documentation of session must support time billed and points discussed.** A narrative description of services must be provided. DHHS will provide reimbursement for a maximum of 16 hours or 64 units of individual sessions per contract year for each participant. **Individual sessions may be provided by licensed/certified staff or by staff directly supervised by licensed/certified staff. Licensed/certified staff must co-sign all documentation provided by unlicensed/non-certified staff. Unlicensed/non-certified staff providing individual sessions must attend an approved individualized counseling training prior to providing individual sessions.**

- **Group Sessions and Size**

Group sessions, billed as procedure code S9446-FP, will be measured in 15-minute increments; a group session must last a minimum of 45 continuous minutes; and must address at least five (5) documentation points plus the client's response (Attachment 1- Documentation Points).

Documentation of session must support time billed and points discussed. A narrative description of services must be provided. DHHS will provide reimbursement for a maximum of sixteen (16) hours or 64 units of group sessions per contract year for each participant. Group size will be defined as at least two (2), but not more than fifteen (15) participants. Groups larger than fifteen (15) are not billable as Medicaid services. Providers must maintain an attendance log for each group session. Curricula must be age/reading level appropriate. Participants may only attend each curriculum once. **Group sessions may be provided by licensed/certified staff or by staff directly supervised by licensed/certified staff. Licensed/certified staff must co-sign all documentation provided by unlicensed/non-certified staff.**

- **Time Limit for Enrollment in MAPPS – Individual and Group Sessions**

Medicaid will provide reimbursement for MAPPS for a period of up to sixteen (16) hours of individual sessions and sixteen (16) hours of group sessions for each participant per contract year. Services in excess of these guidelines must be submitted to a DHHS for approval prior to delivery of the service. Requests must be in written format specifying the participant's individualized risk factors that necessitate additional units of service

- **Billing Codes for MAPPS**

<u>Procedure Code</u>	<u>Description</u>	<u>Unit of Service</u>	<u>Frequency</u>
*T1023-FP	Screening to determine the appropriateness of an individual for participation in a specified program, project, or treatment protocol	15 minutes	8 units per contract year
S9445-FP	Patient education, Individual	15 minutes	64 units per contract year
S9446-FP	Patient education, Group	15 minutes	64 units per contract year

*T1023-FP is to be provided by **licensed or certified staff only**.

Statewide MAPPS rates will be incorporated in contracts on an annual basis.

- **Documentation**

All provider forms must contain the content included in the attached samples along with a narrative description of the service (Screening Form-Attachment 2; Individual or Group Session Form-Attachment 3).

- **Evidence-Based Curricula**

Providers must continue to use evidence-based curricula when conducting group sessions. Curricula must be age/reading level appropriate. Participants may only attend each curriculum once.

If you have any questions concerning these policy changes, please contact your Medicaid program manager at (803) 898-4614. Your continued support of the Medicaid Program is greatly appreciated.

/s/

Robert M. Kerr
Director

RMK/bghh

Attachments

NOTE: To receive Medicaid bulletins by email or to sign up for Electronic Funds Transfer of your Medicaid Payment, please go to the following link for instructions:

<http://www.dhhs.state.sc.us/ResourceLibrary/E-Bulletins.htm>

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

DOCUMENTATION POINTS

S9445-FP - Patient Education, not otherwise classified, non-physician provider, Individual, per session. Address a minimum of three (3) documentation points from the list below plus the client's response.

S9446-FP - Patient Education, not otherwise classified, non-physician provider, Group, per session. Address a minimum of five (5) documentation points from the list below plus the client's response.

- 1) Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention
- 2) Information on the importance of family planning, responsible sexual behavior, and its affect on overall reproductive health
- 3) Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention
- 4) Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention
- 5) Discussion of the benefits of delaying pregnancy
- 6) Discussion of the long and short-term health risks related to early sexual activity
- 7) Discussion of birth control methods, including abstinence, and the options available
- 8) Instruction on the proper and appropriate use of birth control methods
- 9) Importance of compliance with prescribed family planning methods and follow up medical visits
- 10) Information on the benefits and risks of long term birth control methods
- 11) Identification of family planning problems
- 12) Discussion of the availability of other health care resources related to family planning
- 13) Information on STDs and prevention of STDs as it relates to reproductive health and family planning.

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES SCREENING FORM

1. Name of Participant: (First, Middle Initial, Last) _____

2. Case Number Identification:

Medicaid Number	
Social Security Number	
Patient Account Number	

3. Eligibility: (Check One) ☐ Medicaid ☐ Foster Care ☐ Child Protective Services

4. Date of Assessment: (Month, Date, Year) _____

5. Age of Participant: _____ Date of Birth: (Month, Date, Year) _____

6. Gender of Participant: ☐ Male (M) ☐ Female (F)

7. Racial or Ethnic Background of Participant: (Check one)

- | | |
|-----------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> White or Anglo, Not of Hispanic Origin | <input type="checkbox"/> Asian or Pacific Islander |
| <input type="checkbox"/> Black, Not of Hispanic Origin | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Other: _____ |

8. Parent/Guardian: _____ SSN: _____

Environmental

9. Address of Participant:

Street Address:		
Mailing Address: (If Different from Street Address)		
City/Town:	State:	Zip Code:
Telephone: (Home)	(Other)	<input type="checkbox"/> No Telephone

10. Household Members:

Name	Relationship to Participant	Age	Grade	School or Place of Employment of Household Members

11. Financial Support: (Check All That Apply)

☐ Employment ☐ Unemployment Benefits ☐ Family Independence ☐ Food Stamps
☐ Social Security ☐ Disability ☐ Other: (Specify) _____

12. Dwelling and Living Conditions:

☐ Apartment ☐ House ☐ Manufactured Home ☐ Public Housing
☐ Own ☐ Rent ☐ Housing Assistance ☐ Other: _____

• Condition of the Home: _____

13. Access to Transportation: (Check One)

☐ Have Transportation ☐ No Transportation ☐ Have Access to Transportation ☐ No Access to Transportation

14. Name of the Head of Household: _____ SSN: _____

15. Household Income: (Check One)

☐ Less than \$9,900 ☐ \$10,000 - \$12,000 ☐ \$12,001 - \$14,999 ☐ Over \$15,000

16. Employment Status of the Mother/Guardian: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Other: _____

17. Employment Status of the Father/Guardian: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Other: _____

18. Martial Status of Parent (s): ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Other: _____

19. Does Parent (s), guardian or other household member have a history of drug/alcohol abuse?

☐ Yes ☐ No ☐ Unknown

If yes, specify name of individual and relationship to participant: _____

Type of drug/alcohol: _____

Referral/ Health Risk Factors

20. What was the referral source for MAPPS? (Check One)

☐ DSS ☐ Teacher ☐ Counselor ☐ Relative ☐ Friend ☐ Other: (Specify) _____

21. Referral Risk Factor (s): (Check All That Apply)

☐ Parent (s)/Sibling were Pregnant and/or Teen Parents ☐ Sibling Pregnant and/or Teen Parent
☐ Participant is a Teen Parent ☐ Peer Pressure to engage in sexual activity ☐ Participant Sexually Active

22. Is the participant currently sexually active? ☐ Yes ☐ No

If no, has the participant ever used a birth control method? ☐ Yes ☐ No

23. Has the participant ever used a birth control method? ☐ Yes ☐ No

Method Used: (Check All That Apply)

☐ Birth Control Pills ☐ Condom ☐ IUD ☐ Diaphragm ☐ Norplant ☐ Depo-Provera Shot
☐ Rhythm ☐ Other: _____

24. Does the participant understand or know the health risks associated with becoming sexually active? ☐ Yes ☐ No

25. Has the participant ever had a STD? ☐ Yes ☐ No If yes, specify: _____

26. Has the participant ever experimented with alcohol, tobacco, and/or other drugs? ☐ Yes ☐ No

If yes, what kind? _____

Educational/Career

27. Name of school the participant attends: _____

28. Present grade of participant: _____

29. Special needs of the participant: (Check All That Apply)

☐ None ☐ Attention Deficit Disorder (ADD) ☐ Learning Disability ☐ Emotionally Handicapped
☐ Other: (Specify) _____

30. What are the parent/guardian's educational/career goals for the participant? (Check One)

☐ Partial High School ☐ High School Diploma ☐ College (B.S., etc.) ☐ Professional Degree (Ph.D., etc.)

☐ Technical School ☐ Work ☐ Don't Know ☐ Other: _____

What are the participant's education/career goals? (Check One)

☐ Partial High School ☐ High School Diploma ☐ College (B.S., etc.) ☐ Professional Degree (Ph.D., etc.)

☐ Technical School ☐ Work ☐ Don't Know ☐ Other: _____

31. Does the participant engage in extracurricular activities? ☐ Yes ☐ No

If yes, list activities: _____

32. How does the participant spend his/her free time?

After School: _____

Weekends: _____

33. Does the participant have any household rules to follow? ☐ Yes ☐ No

If yes, what are some household rules that the participant has to follow? (Keep Room Clean, Do Housework, Wash Dishes or Cook, Curfew, No Dating, Do School Work, etc.)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Does the participant abide by the rules? ☐ Always ☐ Most of the Time ☐ Sometimes ☐ Rarely ☐ Not at all

34. Do the household rules cause any conflict for the parent/guardian and the participant? ☐ Yes ☐ No

If yes, explain: _____

What are the parent/guardian's and the participant's feelings about the household rules? _____

35. Does the participant have a curfew? ☐ Yes ☐ No

If yes, specify time and day (s) of the week: _____

Does the participant adhere to the curfew? ☐ Always ☐ Most of the Time ☐ Sometimes ☐ Rarely ☐ Not At All

36. Does participant have friends? ☐ Yes ☐ No

If yes, gender and age? _____

When they spend time together, what do they do? _____

How does the participant get along with friends? _____

37. How does the participant get along with adults? (Including teachers) _____

**MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES
PATIENT EDUCATION, INDIVIDUAL OR GROUP, NOT OTHERWISE
CLASSIFIED, NON-PHYSICIAN PROVIDER, PER SESSION**

Participant's Name: _____

Date of Service: _____ **DOB:** _____ **Age:** _____

Medicaid Number: _____ ☐ **Individual** ☐ **Group**

Place: _____ **Units of Service:** _____

☐ Participant's Home ☐ Office ☐ School ☐ Other

Risk Factors: (Check All That Apply)

☐ Parent (s)/Sibling were Pregnant and/or Teen Parents ☐ Sibling Pregnant and/or Teen Parent
☐ Participant is a Teen Parent ☐ Peer Pressure to engage in sexual activity ☐ Participant Sexually Active

Check the Documentation Points discussed:

- ☐ 1. Information on the importance of family planning and it being a health priority
- ☐ 2. Discussion of the options and issues of birth control methods, including abstinence
- ☐ 3. Discussion of the benefits of abstinence
- ☐ 4. Discussion of the benefits of delaying sexual activity
- ☐ 5. Discussion of the benefits of delaying pregnancy
- ☐ 6. Discussion of the long and short term health risks related to early sexual activity
- ☐ 7. Outlining the benefits and risks of long term birth control methods
- ☐ 8. Importance of compliance with prescribed family planning methods and follow up visits
- ☐ 9. Instruction on the proper or appropriate use of birth control methods
- ☐ 10. Identification of family planning problems
- ☐ 11. Information on STDs and prevention of STDs as it relates to family planning
- ☐ 12. Discussion of adolescent development as it relates to human growth, development and sexuality
- ☐ 13. Discussion of the availability of other health care resources related to family planning
- ☐ 14. The client's response and participation level related to family planning issues
(The client's response related to family planning must be included as a documentation point for all sessions.)
- ☐ 15. Treatment plan to resolve identified problems (lifestyle changes, etc.)
(This documentation point is to be used for individual sessions (S9445-FP). An individual session is a one-on-one counseling session provided by licensed or certified staff. Individual sessions may be with the participant; the participant's parent; or the participant and parent. Providers must take reasonable steps to ensure that their communication with the participant is confidential.)